X2014-452

PRINTED: 03/15/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504009	A. BUILDING _____ B. WING _____	03/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY This state psychiatric hospital licensing survey was conducted at Navos on 3/3/2014- 3/4/2014 by Lisa Mahoney, MPH, Stephen Mickschl, MS, RN and Alex Giel, REHS as an orientee. ASE #TTOK11 POC received: 4/2/14 Progress Report received. 6/2/14 Lisa Mahoney 6/4/14	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; *HOW the deficiency will be* corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on <u>March 31, 2014.</u> 4. Return the original report with the required signatures to: Lisa Mahoney, MPH Public Health Advisor 3 Office of Investigations and Inspections P.O. Box 47874 Olympia, WA 98504-7874	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: VP Finance & General Counsel — (X6) DATE: 5/3/14

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L 690	Continued From Page 1	L 690		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide *infection control program, which* includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: Based on review of infection control documents, *review of policy and procedure and administrative* staff interview, the hospital failed to have evidence that Infection Control (IFC) policy and procedure directives were followed regarding collection and analysis of data. Findings: 1. Per review of policy and procedure titled "Infection Control Operations", effective 3/18/2011 under the heading "Implementation" paragraph 5 *states*, "*NAVOS Investigates any infectious* disease outbreak...". During the IFC staff interview regarding program operations, the hospital was not able to provide evidence of infectious disease tracking, investigations and any corrective actions for at least the past fifteen (15) months. 2. Per review of policy and procedure titled "Methods of Surveillance", effective 3/25/2011, under the heading "Employees and Health Care Workers", paragraph A states, "Information is *obtained from Nursing regarding any nursing* employees or health care workers who have to leave work due to illness." During the IFC staff	L 690		

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L 690	Continued From Page 2 interview regarding program operations, the hospital was not able to provide evidence that this process was implemented, that data existed, and the data was analyzed and reported, for at least the past fifteen (15) months. 3. On 3/4/2014, between 11:00 AM and 12:00 PM, *during a meeting to discuss the facility's Infection* Control program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) confirmed the above findings.	L 690		
L 695	322-100.1B INFECT CONTROL-REVIEW WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (b) A review process, using definitions and criteria established by the infection control committee, to determine if staff and patient infections are nosocomial; This RULE: is not met as evidenced by: Based on review of infection control documents *and administrative staff interview, the hospital* failed to show evidence that they implemented a review process to determine which infections were nosocomial (hospital-acquired). Findings:	L 695		

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L 695	Continued From Page 3 On 3/4/2014, between 11:00 AM and 12:00 PM, during a meeting to review the facility's Infection Control Program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) confirmed that for at least the past fifteen (15) months, there was no active process to determine if staff or patient infections were nosocomial.	L 695		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This RULE: is not met as evidenced by: Based on review of infection control documents, review of policies and procedures and administrative staff interview, the hospital failed to provide evidence that staff members followed Infection Control (IFC) policy and procedure directives regarding collection and analysis of environmental surveillance data. Findings: 1. Per review of policy and procedure titled "Infection Control Operations", effective 3/18/2011	L 710		

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L 710	Continued From Page 4 under the heading "Implementation" paragraph 4 states, "The Housekeeping Supervisor does routine Infection Control Inspection walkthroughs of each floor to identify Infection Control problems. These problems result in immediate action and/or reporting to the facilities department for action." 2. On 3/4/2014, between 11:00 AM and 12:00 PM, during a meeting to discuss the facility's Infection Control Program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) confirmed the hospital was not able to provide evidence that staff members completed floor inspections to collect data on any observed problems; nor did staff members report problems for immediate corrective actions for at least the past fifteen (15) months.	L 710		
L 715	322-100.1E INFECT CONTROL-PROVISIONS WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (f) Provisions for: (i) Providing consultation regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent	L 715		

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L 715	Continued From Page 5 with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to provide oversight for appropriate products for disinfection of patient care areas. Findings: 1. Reference Sheet Virex II 256 Diversey REF90091 (12/075) EPA Reg. No. 70627-24 States in part, "To Sanitize Non-Food Contact Surfaces: 1. Pre-clean soiled, hard non-porous surfaces. 2. Apply this product until surface is thoroughly wet. 3. Let stand 1 minute, then wipe. Note: Not for use on food contact surfaces or on food preparation areas." 2. On 3/4/2014 at 10:15 AM, Surveyor #3 interviewed a housekeeper, (Staff Member #7) on her/his procedure for disinfecting food contact surfaces. Staff Member #7 indicated s/he sprayed the disinfectant (Virex II 256) on the kitchen counter and then proceeds to wipe it off using a sponge or a towel. Cross-Refer to tag L1485 3. On 3/4/2014 between 11:00 AM and 12:00 PM, Surveyor #1 asked the Director of Nursing Services (Staff Member #1) about their process to provide consultation to contracted housekeeping staff on procedures for cleaning and disinfection of patient care areas. Staff Member #1 reported that	L 715		

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L 715	Continued From Page 6 in the absence of the Housekeeping Manager, who left in December 2013, there has been no oversight of housekeeping staff.	L 715		
L 765	322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control. The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing staff and administrative staff, to: (d) Meet at regularly scheduled intervals, at least quarterly; This RULE: is not met as evidenced by: Based on review of infection control documents and administrative staff interview, the hospital failed to have evidence that Infection Control (IFC) Committee met at least quarterly. Findings: On 3/4/2014, between 11:00 AM and 12:00 PM, during a meeting to review the facility's Infection Control Program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) were not able to provide evidence that IFC meetings had been accomplished for at least the past fifteen (15) months.	L 765		
L 770	322-100.3E INFECT CONTROL-MTG MINUTES WAC 246-322-100 Infection Control.	L 770		

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L 770	Continued From Page 7 The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing staff and administrative staff, to: (e) Maintain written minutes and reports of findings presented during committee meetings; This RULE: is not met as evidenced by: Based on review of infection control documents and administrative staff interview, the hospital failed to show evidence that minutes existed for the Infection Control (IFC) Committee meetings. Findings: On 3/4/2014, between 11:00 AM and 12:00 PM, during a meeting to review the facility's Infection Control Program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) were not able to provide evidence that IFC meeting minutes had been accomplished for at least the past fifteen (15) months.	L 770		
L 775	322-100.3F INFECT CONTROL-RECOMMEND WAC 246-322-100 Infection Control. The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing	L 775		

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L 775	Continued From Page 8 staff and administrative staff, to: (f) Develop a method for forwarding recommendations to the professional staff, nursing, administration, and other committees and departments as appropriate. This RULE: is not met as evidenced by: Based on review of infection control documents, review of policies and procedures and administrative staff interview, the hospital failed to provide evidence that Infection Control (IFC) policy and procedure directives were followed regarding forwarding recommendations to the professional staff, nursing, administration, and other committees and departments. Findings: 1. Per review of a policy and procedure titled "Infection Control Operations", effective 3/18/2011 under the heading "Implementation" paragraph 10 states, "The Infection Control Committee Chair reports monthly at Medical Staff and Executive Medical Staff Meetings". 2. On 3/4/2014, between 11:00 AM and 12:00 PM, during a meeting to review the facility's Infection Control Program, the Director of Nursing Services (Staff Member #1), the Quality Improvement Director (Staff Member #2), the Director of Child, Youth and Family Quality Assurance (Staff Member #3) and the Interim Medical Director (Staff Member #4) were not able to provide IFC documented evidence that any data was being presented to Medical Staff and Executive Medical Staff Meetings, for at least the past fifteen (15) months.	L 775		

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L 795	Continued From Page 9	L 795		
L 795	322-120.4 VENTILATION WAC 246-322-120 Physical Environment. The licensee shall: (4) Provide natural or mechanical ventilation sufficient to remove odors, smoke, excessive heat and condensation from all habitable rooms; This RULE: is not met as evidenced by: Based on observation, the facility failed to provide natural or mechanical ventilation sufficient to remove odors, and condensation from all habitable rooms. Findings: On 3/3/2014 at 1:00 PM, Surveyors #1 and #3 observed strong odors in the restrooms on the second and third patient floors.	L 795		
L 945	322-140.8 TELEPHONE ACCESS WAC 246-322-140 Patient living areas. The licensee shall: (8) Provide a readily available telephone for patients to make and receive confidential calls; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to provide a readily available telephone for patients to make and receive confidential calls. Findings: On 3/3/2014 between the hours of 1:00 and 3:00 PM, Surveyors #1 and #3 observed patients using phones in high traffic areas along the hallways. When asked if there were any areas where	L 945		

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L 945	Continued From Page 10 patients could receive or make confidential phone calls, the Quality Improvement director (Staff Member #2) stated in part "that there were no areas for patients to make private phone calls."	L 945		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record; This RULE: is not met as evidenced by: Based on medical record review, the facility failed to ensure that physically restrained and/or secluded patients were in restraint/seclusion for the shortest duration deemed necessary, for 1 of 3 patients reviewed for restraints (Patient #1). Findings: Per record review, Patient #1 was admitted on 8/9/2013 and discharged on 1/21/2014. The electronic medical record identified that the patient was placed into seclusion on 12/19/2013 at 11:30 AM. The "IP S&R Flow Sheet/Nursing Assessment" form identified at 11:30 AM the only patient behavior recorded stated "quiet". This same recorded observation of the patient's behavior continued every fifteen (15) minutes until 1:00 PM. Surveyor #2 could not find evidence why	L1145		

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L1145	Continued From Page 11 the patient was not released from seclusion since the patient was not demonstrating behaviors requiring continued seclusion.	L1145		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This RULE: is not met as evidenced by: Based on medical record review, the facility failed to ensure that a physician's order for seclusion was obtained for 1 of 3 patients reviewed for restraints (Patient #1). Findings: Per record review, Patient #1 was admitted on 8/9/2013 and discharged on 1/21/2014. The electronic medical record identified that the patient was placed into 4-point physical restraints on 12/12/2013 at 5:30 PM. The "IP S&R Flow Sheet/Nursing Assessment" form identified that the patient was released from physical restraints between 7:15 PM and 7:30 PM. At 7:30 PM, the form identified that the patient was now in "Seclusion" (a form of restraint) until 8:45 PM. Surveyor #2 could not find evidence that a physician order for placing the patient into seclusion had been obtained, nor could the facility show that an order had been obtained.	L1150		

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L1160	322-180.1F SECLUSION EVALUATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (f) A mental health professional or registered nurse shall evaluate the patient when secluded or restrained more than two continuous hours, and re-evaluate the patient at least once every eight continuous hours of restraint and seclusion thereafter. This RULE: Is not met as evidenced by: Based on medical record review, the facility staff failed to complete an evaluation for secluded or physically restrained patients for 1 of 3 patients reviewed for restraints (Patient #1). Findings: 1. Per review of facility policy and procedure titled "Seclusion and Restraint", last revised 4/24/2013, it states "Within one hour of the time the patient was placed in seclusion or seclusion with restraint, a physician, Licensed Independent Practitioner (LIP) or trained RN will complete the assessment portion of the "RN/LIP/MD Assessment and Physician Order Sheet...". 2. Per record review, Patient #1 was admitted on 8/9/2013 and discharged on 1/21/2014. The electronic medical record identified that the patient was placed into 4-point physical restraints on 12/12/2013 at 5:30 PM. The "IP S&R Flow Sheet/Nursing Assessment" form identified that the patient was released from physical restraints	L1160		

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L1160	Continued From Page 13 between 7:15 PM and 7:30 PM and immediately placed into "Seclusion" (a form of restraint) until 8:45 PM. Surveyor #2 could find no evidence that staff members accomplished the required 1:1 assessment after the patient was placed into seclusion.	L1160		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to comply with chapters 246-215, Washington Administrative Code (WAC) for food service. Findings: 1. On 3/3/2014 at 10:50 AM, during a facility tour of dietary equipment, Surveyor #1 observed a personal bag of empty food containers in Refrigerator #6. Reference:, Washington State Retail Food Code, WAC 246-215-06410 (1) 2. On 3/3/2014 at 10:50 AM, during a facility tour of dietary equipment, Surveyor #3 observed multiple refrigerators lacking thermometers to measure air temperature in the unit. The Materials Director (Staff Member #8) confirmed this finding and indicated that staff use surface temperature measuring devices as an alternative to in-place thermometers. Reference: Washington State Retail Food Code,	L1485		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1485	Continued From Page 14 WAC 246-215-04248 (1) and (2). 3. On 3/3/2014 at 11:55 AM and 5:20 PM, Surveyor #1 observed kitchen staff in the second floor kitchen (Staff Member #5 and Staff Member #6) use the dish sink for hand washing . Reference: Washington State Retail Food Code, WAC 246-215-04525 (1) 4. On 3/3/2014 at 5:15 PM, Surveyor #1 observed the disposable hand towel dispenser in the second floor kitchen was empty. This finding was corrected at the time of the survey. Reference: Washington State Retail Food Code, WAC 246-215-06310 (1) 5. On 3/4/2014 at 10:10 AM, Surveyors #1 and #3 observed a member of the housekeeping staff (Staff Member #7) cleaning the 3rd Floor kitchen with gloved hands. S/He then proceeded to remove clean steam tray covers from the dish machine with the same gloves without removing them and performing hand hygiene prior to touching the clean food service equipment. Reference: Washington State Retail Food Code, WAC 246-215-02310 (9) 6. On 3/4/2014 at 10:15 AM, Surveyor #3 interviewed a housekeeper, (Staff Member #7) on her/his procedure for disinfecting food contact surfaces. Staff Member #7 indicated s/he sprayed the disinfectant (Virex II 256) on the kitchen counter and then proceeded to wipe it off using a sponge or a towel. The manufacturer's reference sheet indicates this product is not for use on food contact surfaces. Reference: Washington State Retail Food Code,	L1485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504009	A. BUILDING _____ B. WING _____	03/04/2014

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NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

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L1485	Continued From Page 15 WAC 246-215-07220 Cross-Refer to tag L0715	L1485		
L1525	322-230.2H FOOD SERVICE-MENU PLANNING WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (h) Ensuring all menus: (i) Are written at least one week in advance; (ii) Indicate the date, day of week, month and year; (iii) Include all foods and snacks served that contribute to nutritional requirements; (iv) Provide a variety of foods; (v) Are approved in writing by the dietitian; (vi) Are posted in a location easily accessible to all patients; and (vii) Are retained for one year; This RULE: is not met as evidenced by: Based on interview and document review, the facility failed to ensure that all menus were approved in writing by the dietician. Findings: On 3/4/2014 at 3:30 PM, Surveyor #1 interviewed the Director of Nursing Services (Staff Member #1) about menu plans for the facility. The facility's dietician was unavailable for interview at the time of the survey. A contracted food service supplier provides monthly menus to the facility. A review of menus for February and March 2014, revealed that they are not approved in writing by the	L1525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L1525	Continued From Page 16 facility's dietician. Staff Member #1 confirmed this finding.	L1525		